

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041319</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manorcare at Palos Heights West</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/00</u> to <u>05/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>11860 Southwest Hwy</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(708)361-4555</u> Fax # <u>(708)361-3777</u>		(Type or Print Name) <u>Barry Lazarus</u>	
IDPA ID Number: <u>520886946016</u>		(Title) <u>Vice President - Director of Reimbursement</u>	
Date of Initial License for Current Owners: <u>04/15/96</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> GOVERNMENTAL		(Firm Name & Address) _____	
<input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Individual <input type="checkbox"/> State		(Telephone) <u>()</u> Fax # ()	
<input type="checkbox"/> Trust <input type="checkbox"/> Partnership <input type="checkbox"/> County		MAIL TO: OFFICE OF HEALTH FINANCE	
IRS Exemption Code _____ <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Other _____		ILLINOIS DEPARTMENT OF PUBLIC AID	
"Sub-S" Corp. _____ Limited Liability Co. _____		201 S. Grand Avenue East	
Trust _____ Other _____		Springfield, IL 62763-0001	
In the event there are further questions about this report, please contact:		Phone # (217) 782-1630	
Name: <u>Gary Geise</u> Telephone Number: <u>(419)252-5731</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Manorcare at Palos Heights West# 0041319 Report Period Beginning: 06/01/00 Ending: 05/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,792</u>	<u>2,168</u>	<u>11,003</u>	<u>18,963</u>	8
9	SNF/PED					9
10	ICF	<u>8,269</u>	<u>10,413</u>	<u>2,021</u>	<u>20,703</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,061</u>	<u>12,581</u>	<u>13,024</u>	<u>39,666</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.56%

D. How many bed-hold days during this year were paid by Public Aid?

176 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/15/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 60 and days of care provided 9,707Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/01 Fiscal Year: 05/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/00

Ending:

05/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	233,550	17,906	2,837	254,293	1,806	256,099		256,099		1
2	Food Purchase		156,252		156,252		156,252	(137)	156,115		2
3	Housekeeping	120,295	19,482	2,253	142,030		142,030		142,030		3
4	Laundry	40,973	11,905	1,516	54,394		54,394		54,394		4
5	Heat and Other Utilities			142,391	142,391	8,280	150,671		150,671		5
6	Maintenance	23,654	6,401	53,408	83,463		83,463		83,463		6
7	Other (specify):* Medical Waste			664	664		664		664		7
8	TOTAL General Services	418,472	211,946	203,069	833,487	10,086	843,573	(137)	843,436		8
	B. Health Care and Programs										
9	Medical Director			15,700	15,700		15,700		15,700		9
10	Nursing and Medical Records	1,724,768	176,745	10,999	1,912,512	32,722	1,945,234		1,945,234		10
10a	Therapy	364,164	2,764	60,901	427,829		427,829		427,829		10a
11	Activities	49,273	3,221	2,638	55,132		55,132		55,132		11
12	Social Services	28,553	76		28,629		28,629		28,629		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,166,758	182,806	90,238	2,439,802	32,722	2,472,524		2,472,524		16
	C. General Administration										
17	Administrative	68,953		361,838	430,791	(70,296)	360,495		360,495		17
18	Directors Fees										18
19	Professional Services			7,027	7,027	(7,027)					19
20	Dues, Fees, Subscriptions & Promotions			76,283	76,283		76,283	(37,248)	39,035		20
21	Clerical & General Office Expenses	191,176	47,681	36,738	275,595	7,027	282,622	14,307	296,929		21
22	Employee Benefits & Payroll Taxes			643,075	643,075	(17,318)	625,757		625,757		22
23	Inservice Training & Education			1,167	1,167		1,167		1,167		23
24	Travel and Seminar			3,732	3,732		3,732		3,732		24
25	Other Admin. Staff Transportation			38,712	38,712		38,712		38,712		25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):* Personal Purchases							(373)	(373)		27
28	TOTAL General Administration	260,129	47,681	1,168,572	1,476,382	(87,614)	1,388,768	(23,314)	1,365,454		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,845,359	442,433	1,461,879	4,749,671	(44,806)	4,704,865	(23,451)	4,681,414		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Palos Heights West #0041319 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			303,413	303,413	44,806	348,219		348,219			30
31	Amortization of Pre-Op. & Org.			22,455	22,455		22,455		22,455			31
32	Interest											32
33	Real Estate Taxes			321,869	321,869		321,869		321,869			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			54,279	54,279		54,279		54,279			35
36	Other (specify):*											36
37	TOTAL Ownership			702,016	702,016	44,806	746,822		746,822			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,608	9,887	267,495		267,495		267,495			39
40	Barber and Beauty Shops		(1,102)	31,166	30,064		30,064		30,064			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* IV Drugs		79,554		79,554		79,554		79,554			43
44	TOTAL Special Cost Centers		336,060	106,753	442,813		442,813		442,813			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,845,359	778,493	2,270,648	5,894,500		5,894,500	(23,451)	5,871,049			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning: 06/01/00

Ending: 05/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(137)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(496)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(373)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	15,559	21		24
25	Fund Raising, Advertising and Promotional	(37,248)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Inc. & Misc.	(756)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,451)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (23,451)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare at Palos Heights West

ID# 0041319

Report Period Beginning: 06/01/00

Ending: 05/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Palos Heights West# 0041319

Report Period Beginning:

06/01/00

Ending:

05/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(137)	0	0	0	0	0	0	0	0	0	0	(137)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(137)	0	0	0	0	0	0	0	0	0	0	(137)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(37,248)	0	0	0	0	0	0	0	0	0	0	(37,248)	20
21	Clerical & General Office Expenses	14,307	0	0	0	0	0	0	0	0	0	0	14,307	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(373)	0	0	0	0	0	0	0	0	0	0	(373)	27
28	TOTAL General Administration	(23,314)	0	0	0	0	0	0	0	0	0	0	(23,314)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,451)	0	0	0	0	0	0	0	0	0	0	(23,451)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Manorcare at Palos Heights West# 0041319

Report Period Beginning:

06/01/00

Ending:

05/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 361,838	HCR ManorCare, Inc.	100.00%	\$ 361,838	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management Fees	35,500	Heartland Management Services	100.00%	35,500		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 397,338			\$ 397,338	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Palos Heights West # 0041319 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Palos Heights West # 0041319 Report Period Beginning: 06/01/00 Ending: 05/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR ManorCare, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	\$	\$		0	1
2	1 Dietary - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	671,002	407,536	5,562,112	1,806	2
3	5 Utilities - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	262,823		5,562,112	805	3
4	5 Utilities - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	2,777,349		5,562,112	7,475	4
5	10 Nursing - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	6,096,791	4,282,378	5,562,112	18,670	5
6	10 Nursing - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	5,221,432	3,383,186	5,562,112	14,052	6
7	17 General & Admin. - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	23,025,730	19,694,773	5,562,112	70,512	7
8	17 General & Admin. - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	82,128,599	31,955,235	5,562,112	221,030	8
9	22 Employees Benefits - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	2,724,065		5,562,112	8,342	9
10	22 Employees Benefits - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	(9,534,453)		5,562,112	(25,660)	10
11	30 Depreciation - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	74,480		5,562,112	228	11
12	30 Depreciation - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	16,563,680		5,562,112	44,578	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 130,011,498	\$ 59,723,108		\$ 361,838	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America National		X	To fund fixed asset additions		05/21/01	\$ 118,340	\$ 118,340			\$	1	
2	Trust & Savings Assoc.											2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 118,340	\$ 118,340			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 118,340	\$ 118,340			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Manorcare at Palos Heights West**# **0041319** Report Period Beginning: **06/01/00** Ending: **05/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$ 289,654	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 313,299	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 23,645	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 298,224	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 321,869	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 134,748	8	
	1997 282,483	9	
	1998 287,987	10	
	1999 304,857	11	
	2000 304,857	12	
Line 2 = \$152,429 for 1st half 2000 + \$160,870 2nd half for 1999.		13	FOR OHF USE ONLY
Line 4 = \$281,994 (152,429 for 2nd half of 2000 + 129,565 for Jan-May 2001) + \$16,230 adjustment for prior year.		13	FROM R. E. TAX STATEMENT FOR 2000 \$
Line 12 is an estimate from the 1st half of 2000 tax bill, final 2000 tax bill not received yet.		14	PLUS APPEAL COST FROM LINE 5 \$
		15	LESS REFUND FROM LINE 6 \$
		16	AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Manorcare at Palos Heights West COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0041319
CONTACT PERSON REGARDING THIS REPORT Gary Geise
TELEPHONE (419) 252-5731 FAX #: (419) 252-5548

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 47,653

B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1994</u>	\$ <u>705,000</u>	1
2					2
3	TOTALS			\$ <u>705,000</u>	3

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/00

Ending:

05/31/01

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1996	\$ 5,345,094	\$ 134,023		\$ 134,023	\$	\$ 680,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					47,280		47,280		190,879	9
10				1996	398,017						10
11				1997	171,094						11
12		GENERAL CONTRACTOR FEES		1998	1,362						12
13		SECURITY SYSTEM		1998	15,860						13
14		CORPORATE OVERHEAD		1998	1,651						14
15		LANDSCAPING		1998	2,025						15
16		INSTALL CURBS & SIDEWALKS		1998	5,880						16
17		GATES/FENCE		1998	5,880						17
18		ENTRYWAY WORK		1998	10,317						18
19		CARPENTRY WORK		1998	4,732						19
20		ELECTRICAL		1998	4,143						20
21		DEVELOPERS		1998	5,704						21
22		SIGN		1998	11,862						22
23		DOOR/WINDOW		1999	813						23
24		CAMERA/AUDIO DOOR ENTRY		1999	4,410						24
25		REMOVE, REPITCH, REPLACE QUARRY TILE IN KITCHEN		1999	4,672						25
26		SECO / THERMA HEAT SYSTEM		1999	2,873						26
27		BUILDING IMPROVEMENTS		1999	14,918						27
28		PUSHBUTTON DOOR LOCKS		2000	1,705						28
29		ADDITIONAL IMPROVEMENTS		2000	2,886						29
30		CARPET IN RESIDENT ROOMS		2000	930						30
31		BUILDING IMPROVEMENTS		2000	67,860						31
32		ACCESS CONTROL KEY PAD		2000	753						32
33		CAMERA SYSTEM		2001	925						33
34		WATER HEATER		2001	9,875						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,096,241	\$ 181,303		\$ 181,303	\$	\$ 871,579	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 949,132	\$ 122,110	\$ 122,110	\$		\$ 575,248	71
72	Current Year Purchases	76,716						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			44,806	44,806			74
75	TOTALS	\$ 1,025,848	\$ 122,110	\$ 166,916	\$ 44,806		\$ 575,248	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,827,089	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 303,413	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 348,219	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,806	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,446,827	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 54,279 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a	3352 hrs	\$ 97,922		
2	Licensed Speech and Language Development Therapist	10a	hrs			78	1,952		78	1,952	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a	2494 hrs	62,040	20	497	647	2,514	63,184	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39,2	# of prescrpts				257,608		257,608	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs							10	
11	Exceptional Care Program									11	
12										12	
13	Other (specify): X-ray & Lab	39,3				9,887			9,887	13	
14	TOTAL			\$ 159,962	98	\$ 12,336	\$ 260,372	5,944	\$ 432,670	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 79,516	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (160,944))	1,381,971		3
4	Supply Inventory (priced at)	34,342		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,302		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,504,131	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	705,000		13
14	Buildings, at Historical Cost	6,096,241		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,025,848		16
17	Accumulated Depreciation (book methods)	(1,446,827)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,380,262	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,884,393	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 15,142	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	175,143		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	281,994		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Trade Payable & Liabilities	77,270		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 549,549	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 549,549	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,334,844	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,884,393	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,479,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,479,736	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,569,804	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,569,804	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,714,696)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,714,696)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,334,844	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,127,614	1
2	Discounts and Allowances for all Levels	(1,365,819)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,761,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,383,975	6
7	Oxygen	(1,326)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,382,649	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	877	12
13	Barber and Beauty Care	28,290	13
14	Non-Patient Meals	137	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	246,897	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,578	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	9,239	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 316,018	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	252	28
28a	Late charges	3,590	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,842	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,464,304	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	833,487	31
32	Health Care	2,439,802	32
33	General Administration	1,476,382	33
	B. Capital Expense		
34	Ownership	702,016	34
	C. Ancillary Expense		
35	Special Cost Centers	377,113	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,894,500	40
41	Income before Income Taxes (line 30 minus line 40)**	1,569,804	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,569,804	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,492	3,816	\$ 104,796	\$ 27.46	1
2	Assistant Director of Nursing	1,492	1,630	39,595	24.29	2
3	Registered Nurses	27,531	30,079	519,442	17.27	3
4	Licensed Practical Nurses	23,010	25,140	338,726	13.47	4
5	Nurse Aides & Orderlies	77,082	84,218	700,808	8.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,015	6,522	173,439	26.59	7
8	Rehab/Therapy Aides	10,567	11,458	190,725	16.65	8
9	Activity Director	5,339	5,832	49,273	8.45	9
10	Activity Assistants					10
11	Social Service Workers	1,867	2,040	28,553	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,908	28,133	233,550	8.30	15
16	Dishwashers					16
17	Maintenance Workers	1,682	1,841	23,654	12.85	17
18	Housekeepers	15,025	16,459	120,295	7.31	18
19	Laundry	5,375	5,885	40,973	6.96	19
20	Administrator	2,390	2,080	68,953	33.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,325	14,999	191,176	12.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,846	2,016	21,401	10.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,946	242,148	\$ 2,845,359 *	\$ 11.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	15,700	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	21,959	10a, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,659		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	11	\$ 520	10, 3	50
51	Licensed Practical Nurses	41	1,404	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	52	\$ 1,924		53

Facility Name & ID Number Manorcare at Palos Heights West

0041319

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XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$4608
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,524 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 137
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.